

Documentation Checklist for Students and Practice Educators

TYPE OF DOCUMENTATION THIS FORM RELATES TO

e.g. Progress notes, initial interview, specialist assessment (name), standardised assessment (name), home visit reports, discharge summaries, referrals to others, forms/requests/requisitions

SPECIFY REFERENCE MATERIAL READ/USED

e.g. Documentation policy, assessment manual, note formats (S.O.A.P, ISBAR), Standard forms/templates

SUMMARISE THE MOST IMPORTANT POINTS FROM THE REFERENCE MATERIAL REGARDING DOCUMENTATION

- ☐
- ☐
- ☐

ASSESSMENT

1. Conduct self-assessment of your documentation using checklist below
2. Submit this form along with your sample documentation, to your practice educator for review

Item	Student's Self- assessment ☑ or ☒	Practice Educator's Assessment ☑ or ☒	Comments
Correct use of local format, heading, subheadings etc			
Name/address/or patient number identified			
Date of event/intervention included			
Others present noted			
Consent and confidentiality obtained and explained			
Correct language (reported, observed etc used)			
Conversations, observations or interviews are recorded in sufficient detail for occupational issues or plans/actions agreed can be clearly and explicitly identified			

Item	Student's Self- assessment ☑ or ☒	Practice Educator's Assessment ☑ or ☒	Comments
Information is presented clearly and concisely using language which is easily understood			
Acronyms and abbreviations are agreed versions with this employer			
Non-judgmental, neutral, non-derogatory, non-emotive language used			
Factual and objective to the event/s			
The information is presented in a respectful, appropriate and thoughtful manner, which takes into consideration the cultural, spiritual, religious and personal context(s) of the client			
Relevant detail on the purpose, findings and outcome of the event/intervention			
All identified recommendations are justified			
Client/carer safety/risk is considered			
Client preferences, choice, priorities, goals are included			
Information is legible			
Sufficient detail for others to identify the outcomes, occupational performance issues, goals, and intervention plan with timeframes if appropriate			
Clinical reasoning is evident to support the next intervention /plan			
Other issues to be added by supervisor:			

ITEMS IDENTIFIED THAT MEET THE STANDARDS EXPECTED

e.g. Student writes in logical format, accurate use of terminology, written in consideration of audience

ITEMS IDENTIFIED THAT NEED FURTHER DEVELOPMENT

e.g. Student needs to work on grammar, objectivity, forming clinical impressions

FOLLOW-UP PLAN - AGREED WITH STUDENT/PRACTICE EDUCATOR INCLUDING FREQUENCY AND TIMEFRAME

e.g. Student is to complete two further initial interviews and present the two draft reports in supervision within two days.

OUTCOME OF PLAN

- ☐ COMPETENT - Has completed this type of documentation to the required standard on occasions
- ☐ MET STANDARD / CONSOLIDATION REQUIRED - Has met the expected standard for this documentation on this occasion but now needs to show consolidation
- ☐ YET TO MEET STANDARD / PRACTICE REQUIRED - Further Documentation to be completed to evidence emerging competence
- ☐ ONGOING DEVELOPMENT REQUIRED - Needs to have documentation as a learning objective on the next placement due to continued concerns as listed above

Practice Educator: Name..... Signed.....